Dept of Labor & Industries
Crime Victims Comp Program
PO Box 44520
Olympia WA 98504-4520

STATEMENT FOR HOME NURSING SERVICES

DO NOT WRITE IN SPACE >

CLAIMANT'S NAME IN FULL	Last	First	Middle	Claim Number
Address				Social Security Number (for ID only)
City		State	ZIP	

Date of Injury	Name of referring physician or other source	Referring physician provider number

DIAGNOSIS OR NATURE OF ILLNESS OR INJURY
(use ICDA-9) Designate left or right when applicable.
1.
2.
3.
4.
5.

For glasses, advise if old Rx was available? ☐ Yes ☐ No

Give hospitalization dates for inpatient services
Admitted ____/____/____
Discharged ____/____/____

REFUND CERTIFICATION
I hereby certify under penalty of perjury that this is a true and correct claim for the necessary expenses incurred by me, that the claim is just and due and that no payment has been received by me on account thereof.
CLAIMANT'S SIGNATURE:

FROM DATE OF SERVICE	POS	* TOS	PROC CODE	MOD CODE	Describe procedures, medical services, or supplies furnished. Attach lab reports, X-ray findings and any special services.	Dental Tooth Number	Home Nursing: No of hrs/day	Home Nursing: Hourly/ Day rate	GLASSES: OLD RX OD	GLASSES: OLD RX OS	GLASSES: NEW RX OD	GLASSES: NEW RX OS	CHARGES $ ¢	Unit	TO DATE OF SERVICE
1.															
2.															
3.															
4.															
5.															
6.															
7.															
8.															
9.															
10.															
11.															
12.															
13.															

Submission of this bill certifies the material furnished, service provided, expense incurred, or other item of indebtedness as charged in the foregoing bill is a true and correct charge against the state of Washington; that the claim is just and due; that no part of the same has been paid.
Signature: Bill date: ____/____/____

Remarks:

Provider or Supplier name	Provider number	Total Charge
Address		Phone Number
City	State ZIP + 4	Your Patient's Account Number
Federal tax ID number ☐ EIN ☐ SSN		

F800-070-000 statement for home nursing services 4-02

* Place of Service (POS) and Type of Service (TOS) codes on back

INSTRUCTIONS FOR COMPLETING HOME NURSING SERVICES STATEMENT

1. **CLAIMANT'S NAME:** Claimant's full name, last name first.
2. **SOCIAL SECURITY NUMBER:** Record claimant's social security number. It is helpful when the claim number is wrong and the claimant's name is common.
3. **CLAIM NUMBER:** For the claimant receiving services.

   Crime victim claim numbers are six digits preceded by a "V", or five digits preceded by a "VA, VB, VC, VH or VJ".

   Send bills for claims to:
   Crime Victims Compensation Program
   Department of Labor and Industries
   PO Box 44520
   Olympia WA 98504-4520

   Department bill forms are furnished at no charge to the vendor and can be obtained by calling the local department office or the main office in Olympia.
4. **ADDRESS:** The claimant's most current address.
5. **DATE OF INJURY:** This is important and must be included. One person may have several claims, so it is vital the proper claim be identified and charged for services provided. The date of injury positively identifies each claim.
6. **NAME OF REFERRING PHYSICIAN:** The name of the physician who has referred the claimant to you, the provider, for services.
7. **REFERRING PHYSICIAN PROVIDER NUMBER:** The Crime Victims Compensation Program provider account number of the referring physician. The number may be obtained from the referring physician.
8. **DIAGNOSIS:** Not applicable.
9. **FOR GLASSES:** Not applicable.
10. **SERVICES RELATED TO HOSPITALIZATION:** If claimant was hospitalized, record the date admitted and the date discharged.
11. **REFUND CERTIFICATION - FOR CLAIMANT REIMBURSEMENT:** Signature of the claimant who received the care.
12. **ITEMIZATION OF SERVICES AND CHARGES:**
    A. **DATE(s) OF SERVICE:** Record the date for each service provided. For consecutive dates of service, (i.e., home nursing care, attendant care) record both beginning (from-date-of-service column) and ending (to-date-of-service column) dates.
    B. **PLACE OF SERVICE:** A complete list of Place of Service (POS) codes is printed below. Please refer to that list and place the appropriate code in the space provided.
    C. **TYPE OF SERVICE:** Enter "9 (nine)" on each line of service.
    D. **PROCEDURE CODE:** Identifies the procedures used. Enter the appropriate code and describe the procedure. **Enter only one code per line.**
    E. **CODE MODIFIER:** Not applicable.
    F. **DENTAL:** Not applicable.
    G. **HOME NURSING:**
       Number of Hours or Days: Enter number of hours per day or number of days per month.
       Hourly or Daily Rate: Record the rate charged (by the hour or day) for the home nursing services provided.
    H. **GLASSES:** Not applicable.
    I. **CHARGES:** Total line item charge.
    J. **UNIT:** The total of hours if an hourly rate was entered in the home nursing column (item "G") or total of days if a daily rate was entered in the home nursing column (item "G").
13. **PROVIDER'S OR SUPPLIER'S NAME, ADDRESS, ZIP CODE AND TELEPHONE NUMBER:** The provider's or supplier's name and current address. If any of the information changes, notify Provider Registration immediately. (Indicating a new address on the bill **will not** change the department's record of address for the provider.
14. **PROVIDER NUMBER:** Identification number for the provider which is designated by the Crime Victims Compensation Program.
15. **TOTAL CHARGE:** Total of **all** charges for services provided.
16. **YOUR PATIENT'S ACCOUNT NUMBER:** The number you use to identify your patient's account.
17. **BILL DATE:** The date your billing was prepared.
18. **TAX IDENTIFICATION NUMBER:** The provider taxpayer identification number for IRS (Internal Revenue Service) reports.
19. **REMARKS:** Any further information necessary to explain your charge.

ATTACHMENTS
Must have the corresponding claim number listed in the upper right corner of the attachment.

DUE TO THE FACT THAT THE CRIME VICTIMS' BILL RECORDS ARE KEPT ON MICROFILM, BILLS AND ATTACHMENTS MUST BE LEGIBLE AND CLEAR.
The following attachment **is not** acceptable: Office Visit Slips.

REBILLS
If you do not receive payment or notification from the department within ninety (90) days, services may be rebilled. Rebills should be identical to the original bill: same charges, codes and billing dates. Please indicate **"Rebill"** on the bill.
Any inquiries regarding adjustment of charges must be submitted within ninety (90) days from the date of payment to be considered.

PLACE OF SERVICE (POS)

12. Patient's Home
99. Other Unlisted Facility